CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

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PARTICIPATING PROVIDER

A participating provider is a supplier of prosthetic devices that is certified by the American Board for Certification in Orthotics and Prosthetics and has a current, signed participation agreement with the Department of Medical Assistance Services (DMAS).

PROVIDER ENROLLMENT

Any provider of services must be enrolled in the Medicaid/FAMIS Program prior to billing for any services provided to Medicaid/FAMIS clients. A copy of the provider agreement with instructions on how to complete the forms can be found at the DMAS Web site, www.dmas.virginia.gov or by contacting the Provider Enrollment at 1-888-829-5373 (in state toll-free) or (804) 270-5105, fax: (804) 270-7027. All providers must sign and complete the entire application and submit it to the Provider Enrollment Unit at:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

An original signature of the individual providers is required. The Medicaid participation agreement may be time-limited depending on the licensing required. All participating Medicaid providers are required to complete a new application and agreement as a result of any name change or change of ownership.

Upon receipt of the above information, a Medicaid identification number is assigned to each approved provider. This number must be used on all claims and correspondence submitted to Medicaid.

This manual contains instructions for billing and specific details concerning the Medicaid Program. Providers must comply with all sections of this manual to maintain continuous participation in the Medicaid Program.

PARTICIPATION REQUIREMENTS

All providers enrolled in the Medicaid/FAMIS Program must adhere to the conditions of participation outlined in their individual provider agreement. Providers approved for participation in the Medical Assistance Program must perform the following activities as well as any other specified by DMAS:

- Immediately notify the Provider Enrollment Unit at First Health, in writing, of any change in the information, which the provider previously submitted to the Department;

- Ensure freedom of choice to recipients in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the service(s) required and participating in the Medicaid/FAMIS Program at the time the service was performed;

- Ensure the recipient's freedom to reject medical care and treatment;

- Provide services and supplies to recipients in full compliance with Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the grounds of race, color, or national origin;

- Provide services and supplies to recipients in full compliance with the requirements of Section 504 of the Rehabilitation Act of 1973, requiring that all necessary accommodations be made to meet the needs of persons with semi-ambulatory disabilities, sight and hearing disabilities, and disabilities of coordination (refer to the section in this chapter regarding Section 504 of the Rehabilitation Act);

- Not require, as a precondition for admission or continued stay, any period of private pay or a deposit from the resident or any other party;

- Not bill the recipient or Medicaid for missed or broken appointments;

- Accept Medicaid payment from the first day of eligibility, if Medicaid eligibility was pending at the time of admission. A nursing a facility must accept payment back to the date of eligibility, if the resident was in a certified bed, whether or not the facility knew that Medicaid application had been made;

- Provide services and supplies to recipients of the same quality and in the same mode of delivery as provided to the general public;

- Charge the Department of Medical Assitance Services for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public;

- Accept as payment in full the amount established by the Department of Medical Assistance Services. 42 CFR § 447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency;"

- A provider may not seek to collect from the Medicaid recipient, or any financially responsible relative or representative of that recipient, any amount that exceeds

the established Medicaid allowance for the service rendered. For example: if a third party payer reimburses $5.00 out of an $8.00 charge, and Medicaid's allowance is $5.00, then payment in full has been made. The provider may not attempt to collect the $3.00 difference from Medicaid, the recipient, a spouse, or a responsible relative;

- Accept assignment of Medicare benefits for eligible Medicaid recipients;
- Use Program-designated claim forms and billing invoices for the submission of charges;
- Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided. (Refer to the section in this Chapter regarding documentation);
- Such records must be retained for a period of five years from the date of service or as provided by applicable state law, whichever period is longer. If an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved. (Refer to the section in this chapter regarding documentation for records;)
- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities;
- Disclose, as requested by the Department of Medical Assistance Services, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of medical assistance; and
- Hold information regarding recipients confidential. A provider shall disclose information in his or her possession only when the information is used in conjunction with a claim for health benefits or the data are necessary for the functioning of DMAS. DMAS shall not disclose medical information to the public. The provider agrees to comply with the regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the protection of confidentiality and integrity of VMAP information.

REQUIREMENTS OF § 504 OF THE REHABILITATION ACT

Section 504 of the Rehabilitation Act of 1973 provides that no disabled individual shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, each Medicaid provider is responsible for making provision for disabled individuals in their program activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. A compliance notice is printed on the back of checks issued to providers, and, by indorsement, the provider indicates compliance with § 504 of the Rehabilitation Act.

In the event a discrimination complaint is lodged, DMAS is required to provide the Office of Civil Rights (OCR) with any evidence regarding compliance with these requirements.

REQUIREMENTS OF THE CIVIL RIGHTS ACT OF 1964

All providers of care and suppliers of services under the contract with DMAS must comply with the requirements of Title VI of the Civil Rights Act of 1964, which requires that services be provided to Medicaid clients without regard to race, color, or national origin.

DOCUMENTATION OF RECORDS

The provider agreement requires that the medical records fully disclose the extent of services provided to Medicaid clients. Medical records must clearly document the medical necessity for covered services. This documentation must be written at the time the service is rendered and must be legible and clear in the description of the services rendered.
The following elements are required:

- The record must identify the patient on each page.
- Entries must be signed and dated by the responsible participating provider.
- Physician's orders and prescriptions must be included.

UTILIZATION OF INSURANCE BENEFITS

The Virginia Medical Assistance Program is a “last pay” program. Benefits available under Medical Assistance shall be reduced to the extent that they are available through other federal, State, or local programs; coverage provided under federal or state law; other insurance; or third-party liability.

Health, hospital, workers' compensation, or accident insurance benefits shall be used to the fullest extent in meeting the medical needs of the covered person. Supplementation of available benefits shall be as follows:

- **Title XVIII (Medicare)** - Virginia Medicaid will pay the amount of any deductible or coinsurance up to the Medicaid limit for covered health care benefits under Title XVIII of the Social Security Act for all eligible persons covered by Medicare and Medicaid.

- **Workers' Compensation** - No Medicaid Program payments shall be made for a patient covered by Workers' Compensation.

- **Other Health Insurance** - When a client has other health insurance (such as CHAMPUS/TRICARE, Blue Cross-Blue Shield, or Medicare), Medicaid requires that these benefits be used first. Supplementation shall be made by the Medicaid Program when necessary, but the combined total payment from all insurance shall not exceed the amount payable under Medicaid had there been no other insurance.

- **Liability Insurance for Accidental Injuries** - The Virginia Medicaid Program will seek repayment from any settlements or judgments in favor of Medicaid clients who receive medical care as the result of the negligence of another. If a client is treated as the result of an accident and the Virginia Medical Assistance Program is billed for this treatment, Medicaid should be notified promptly so action can be initiated by Medicaid to establish a lien as set forth in the Virginia Code Section 8.01-66.9. In liability cases, providers may choose to bill the third-party carrier or file a lien in lieu of billing Medicaid.

  Regardless of whether Medicaid is billed by the provider for rendered services related to an accident where there is a possibility of third-party liability or if the client reports a third party responsibility, the provider is requested to complete the DMAS-1000 to the attention of the Third-Party Liability Casualty Unit, Virginia Medical Assistance Program, 600 East Broad Street, Richmond, Virginia 23219. (See "Exhibits" at the end of the chapter for a sample of the form.)

TERMINATION OF PROVIDER PARTICIPATION

The participation agreement may be time-limited, with periodic renewals required. DMAS will request a renewal of the Participation Agreement prior to its expiration for providers who have time-limited Medicaid participation agreements.

A participating provider may terminate his participation in Medicaid at any time. Thirty (30) days' written notification of voluntary termination should be made to the Director, Department of Medical Assistance Services.

DMAS may terminate a provider from participation upon thirty (30) days' written notification. Such action precludes further payment by DMAS for services provided recipients subsequent to the date specified in the termination notice.

Section 32.1-325(D)(2) of the *Code of Virginia* mandates that "Any such [Medicaid] agreement or contract shall terminate upon conviction of the provider of a felony."

A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify Medicaid of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of state law.

PROGRAM INFORMATION

Federal regulations governing program operations require Virginia Medicaid to supply program information to all providers. The current system for distributing this information is keyed to the provider number on the enrollment file, which means that each assigned provider receives Program information. Since DMAS does not always know which provider groups have multiple offices or which groups use one central office, providers may receive multiple copies of publications sent to the same location. Individual providers may request that publications not be mailed to them by completing a Mailing Suspension Request form and returning it to the First Health - Provider Enrollment Unit at the address given on the form. The Mailing Suspension Request Form is available on the DMAS website, www.dmas.virginia.gov or by contacting the Provider Enrollment Unit at the address below. The Mailing Suspension Request form must be completed and signed by each provider within the group who is requesting that Program information not be sent. The address is:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-5105 or 1-888-829-5373 (in-state toll-free), fax: 804-270-7027

(See the "Exhibits" section at the end of the chapter for a sample of the form.)

Provider Manuals and manual updates are posted on the DMAS Web site for viewing and downloading. The web address is www.dmas.virginia.gov. Providers are notified of manual updates through messages posted on Medicaid remittance advices.

RECONSIDERATION AND APPEALS OF ADVERSE ACTIONS

The following procedures will be available to all providers when DMAS takes adverse action. Adverse action for purposes of this section includes termination or suspension of the provider agreement and denial of payment for services rendered based on utilization review decisions.

The reconsideration and appeals process will consist of three phases: a written response and reconsideration of the preliminary findings, the informal conference, and the formal evidentiary hearing. The provider will have 30 days to submit information for written reconsideration and will have 30 days' notice to request the informal conference and/or the formal evidentiary hearing.

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (Section 2.2-4000 et seq.) and the State Plan for Medical Assistance provided for in Section 32.1-325 of the Code of Virginia. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the Administrative Process Act.

Any legal representative of a provider must be duly licensed to practice law in the Commonwealth of Virginia.

Repayment of Identified Overpayments

Pursuant to Section 32.l-325.l of the *Code of Virginia*, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When a lump sum cash payment is not made, interest will be added on the declining balance at the statutory rate, pursuant to of the *Code of Virginia*, Section 32.l-3l3.l. Repayment and interest will not apply pending appeal. Repayment schedules must ensure full repayment within l2 months unless the provider demonstrates, to the satisfaction of DMAS a financial hardship warranting extended repayment terms.

EXHIBITS

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First Health Services Corporation

MAILING SUSPENSION REQUEST
SERVICE CENTER AUTHORIZATION
SIGNATURE WAIVER
PHARMACY POINT-OF-SALE

Please review and check the blocks which pertain to you:

- ☐ **MAILING SUSPENSION REQUEST:**
  I do not wish to receive Medicaid memos, forms, or manual updates under the Medicaid provider number given below.

- ☐ **COMPUTER GENERATED CLAIMS:**
  I certify that I have authorized the following service center to submit computer-generated invoices (by modem, diskette or tape) to Virginia Medicaid:

  _____
  (Service Center Preparing Invoices)

  Service center code: _____ **Magnetic Tape RA:** YES NO (Circle One)

  Prior service center code: _____

- ☐ **SIGNATURE WAIVER:**
  I certify that I have authorized submission of claims to Virginia Medicaid which contain my typed, computer generated, or stamped signature.

- ☐ **PHARMACY POINT-OF-SALE AUTHORIZATION (in-state providers only):**
  I wish to submit Point-of-Sale billings to Virginia Medicaid.

I understand that I am responsible for the information presented on these invoices and that the information is true, accurate, and complete. I further understand that payment and satisfaction of these claims will be from federal and state funds and that false claims, statements, documents, or concealment of material facts may be prosecuted under applicable federal and state laws.

PROVIDER NAME: _____

PROVIDER NUMBER: _____ Leave blank, if number pending.

SIGNATURE: _____

DATE: _____

TELEPHONE # _____

Please return completed form to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803
1-804-270-5105

VIRGINIA

Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond, Virginia
23219

THIRD PARTY LIABILITY INFORMATION REPORT

(FOR MEDICAID PROVIDERS' USE)

This form MUST be submitted to the Department of Medical Assistance Services within 30 days after a service is rendered to a Virginia Medicaid recipient for the treatment of accident related injuries. Federal Regulations (42CFR - 433.138) require the Department of Medical Assistance Services to exert positive efforts toward locating liable third parties and to diligently seek refunds of applicable liability payments. Please complete this form to the best of your knowledge to assist us in this effort. Statutory authority is provided for full recovery of funds from liable third parties in Section 8.01-66.9 of the Code of Virginia.

PLEASE TYPE OR PRINT

NAME OF RECIPIENT: _____
(LAST) (FIRST) (MI)

RECIPIENT'S ELIGIBILITY NO. _____ DATE OF INJURY _____

TYPE OF ACCIDENT _____ DATE YOUR SERVICE BEGAN _____
(WORK, AUTO, HOME, GUNSHOT, ETC.)

NAME OF ATTORNEY _____

ADDRESS _____

(IF RECIPIENT HAS AN ATTORNEY, THE FOLLOWING INFORMATION IS NOT NEEDED.)

NAME OF INSURANCE COMPANY _____

ADDRESS _____

NAME OF INSURED PERSON _____

POLICY NO. _____ CLAIM NO. _____

COMMENTS _____

DIAGNOSIS _____ NAME OF PROVIDER _____

IS TREATMENT COMPLETED _____ YES _____ NO

DATE _____ BY _____

Providers will not be involved in litigation or collection attempts by the Department of Medical Assistance Services nor will reimbursement to the provider be withheld as a result of submitting this form.

PLEASE MAIL TO:

THIRD PARTY LIABILITY/CASUALTY
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 E. BROAD STREET, SUITE 1300
RICHMOND, VIRGINIA 23219

DMAS - 1000 R9/87